

POLICY AND COMMUNICATIONS BULLETIN

THE CLINICAL CENTER

Medical Administrative Series

M76-5 (rev.)

20 January 1998

MANUAL TRANSMITTAL SHEET

SUBJECT: Intramural Consultative Services

1. Explanation of Material Transmitted: This issuance sets forth the policy for the provision of intramural consultative services at the Clinical Center. The policy reviewed by the Medical Executive Committee on 20 January 1998 and approved with changes.
2. Material Superseded: MAS No. 76-5 (rev.), dated 7 October 1997
3. Filing Instructions: "Other" Section

Remove: No. 76-5 (rev.), dated 7 October 1997

Insert: No. M76-5 (rev.), dated 20 January 1998

DISTRIBUTION

Physicians, Dentists and Other Practitioners Participating in
Patient Care

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To ensure the delivery of optimal care to patients in the Clinical Center, the following policy for consultative services has been adopted:

1. Requesting a Consultation:

A physician or dentist desiring an intramural consultation should select the appropriate consultant from the "MIS Information — In-house Consultant" list and contact the selected consultant as directed. The NIH telephone operator maintains an up-to-date list of on-call consultants. For consultants with particular expertise not available in-house, requests should be directed to the in-house consultant for that specialty who will assist in identifying an approved outside consultant.

Requests for consultation (official consult forms or MIS printouts when available) should be entered in the patient's chart. Requests should indicate the name and location of the patient, the name and number of the referring physician or dentist, the specific clinical issue to be addressed by the consultant, and whether the consultation is routine, emergent, or for teaching purposes.

2. Performing the Consultation:

Requests for routine consultation will be answered within 24 hours. Emergency consultations shall be delivered as quickly as possible. The consultant's recommendations must be clearly communicated to the primary team. Direct contact with the referring physician is optimal. Written reports must be legible; typed reports are encouraged. Consultants should continue to follow the patient on

a regular basis until the consultant and primary care team agree that services are no longer necessary. Termination of follow-up should be specifically documented in the follow-up consultant's note.

3. Senior Review:

Senior staff physicians will review and sign written recommendations on cases initially seen by junior staff consultants within 24 hours of the junior staff evaluation for routine consultations, and sooner for emergent consultations.

4. Exceptions to Paragraph (3):

Senior clinician review is not required if the consultation request is obviously of a nature routinely handled by the junior consultant and where the requesting physician does not normally expect case review. Such requests would include those for catheter insertions, lumbar punctures, joint aspirations, skin biopsies, etc.